Department of Mental Health & Substance Abuse Services

Certified Peer Recovery Specialist
Employment / Volunteer Summary

The applicant named below is applying for certification as a Peer Recovery Specialist with the State of Tennessee. For Peer Recovery Specialists currently employed or in a volunteer position, the clinical supervisor should complete the following form regarding the applicant's employment or volunteer position, peer support responsibilities and supervisory plan. For questions, please contact the Office of Consumer Affairs and Peer Recovery Services toll-free at 800-560-5767.

Applicant's name_____

Agency _____

Title of applicant's position _____

Does the applicant provide peer recovery services in this position? ❑ YES ❑ NO

Has the applicant provided at minimum 75 hours of peer recovery services? ❑ YES ❑ NO

Start date of employment or volunteer position providing peer recovery services_____

Number of hours assigned to work in this position per week _____

A Certified Peer Recovery Specialist must be under the supervision of a mental health professional in accordance with acceptable guidelines and standards of practice as defined by the State and as defined in the TDMHSAS Licensure rules, Chapter 0940-05-01. Please provide the following information regarding who provides clinical supervision:

Clinical Supervisor's Name _____ Credentials_____

Title _____

Agency/Organization_____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Email _____

Describe the nature of the applicant's work or volunteer responsibilities providing **peer recovery services**. For examples of peer recovery services, see the Scope of Activities in the CPRS Handbook here: http://tn.gov/behavioral-health/topic/certified-peer-recovery-specialist-program. *Note: it is a violation of the CPRS Code of Ethics for CPRS's to provide clinical treatment services.*

_____

_____

_____

_____

_____

_____

Describe in detail the nature of your one-on-one supervision interactions with this applicant:

_____

_____

_____

_____

_____

_____

Describe in detail the professional development plan or goals for the applicant within the agency/organization:

_____

_____

_____

_____

_____

_____

My signature below affirms that all of the information contained in this document is true.

Signature of Clinical Supervisor_____ Date _____